



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HARLINGEN MEDICAL CENTER
3255 W. PIONEER PKWY.
ARLINGTON, TEXAS 76013

Respondent Name

TRAVELERS INDEMNITY CO

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-12-2855-01

MFDR Date Received

May 08, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated May 8, 2012: "OUTLIER REIMBURSEMENT"

Amount in Dispute: \$4,032.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated May 21, 2012: "The Carrier reviewed the billing and denied reimbursement for this code on the basis that it is "C" stats indicate code by Medicare. The "C" status indicator provides that reimbursement for this service is only allowed in an in-patient hospital setting. As Medicare does not allow reimbursement for this procedure in an out-patient setting, the Carrier properly denied reimbursement under Rule 134.403 (i). The Carrier properly denied reimbursement for this procedure in the out-patient setting as no agreement had been negotiated by the parties prior to the services being rendered."

Response Submitted by: Travelers Indemnity Co.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 12 to 13, 2011	Outpatient Hospital Services	\$4,032.90	\$3,345.04

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated January 4, 2012

- W1 – WORKERS COMPENSATION SATTE FEE SCHEDULE ADJUSTMENT
- 89 – PROFESSIONAL FEES REMOVED FROM CHARGES.
- 125 – PAYMENT ADJUSTED DUE TO A SUBMSSIONA/BILLING ERROR(S).
- INCL – PACKAGED SERVICES ARE INCLUDED IN THE APC RATE
- PAYT – 217 – BASED ON PAYER REASONABLE AND CUSTOMARY FEES. NO MAX ALLOWABLE DEFINED BY LEGISLATED FEE ARRANGEMENT. REDUCED TO FAIR AND REASONABLE.
- FEES – REIMBURSEMENT BASED ON MAX ALLOWABLE FEE FOR THIS PROCDURE BASED ON MEDICAL FEE SCHEDULE, OR IF ON IS NOT SPECIFIED, UCR FOR THIS ZIP CODE AREA.
- GL10 – SERVICES BILLED FOR RADIOLOGY, LAB, AND/OR PATHOLOGY B A HOSPITAL SHOULD NORMALLY BE BILLED AT THE TC RATE.
- TX AP – PRICED ACCORDING TO THE STATE APC FEE SCHEDULE RATE.
- TXBP – THIS PROCEDURE CODE MUST BE BILLED WITH THE PROPER TYPE OF BILL CODE PER RULE 134.403(D).

Explanation of benefits dated January 13, 2012

- 18 – DUPLICATED CLAIM/SERVICE.
- DUPP – THESE SERVICES HAVE ALREADY BEEN CONSIDERED FOR REIMBURSEMENT.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75. The recommended payment is \$3.75.
 - Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for

Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$10.94. 125% of this amount is \$13.68. The recommended payment is \$13.68.

- Procedure code 87071 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$13.28. 125% of this amount is \$16.60. The recommended payment is \$16.60.
- Procedure code 87076 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$11.37. 125% of this amount is \$14.21. The recommended payment is \$14.21.
- Procedure code 87186 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$12.17. 125% of this amount is \$15.21. The recommended payment is \$15.21.
- Procedure code 87205 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$6.01. 125% of this amount is \$7.51. The recommended payment is \$7.51.
- Procedure code 81001 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$4.45. 125% of this amount is \$5.56. The recommended payment is \$5.56.
- Procedure code 88305 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0343, which, per OPPS Addendum A, has a payment rate of \$36.48. This amount multiplied by 60% yields an unadjusted labor-related amount of \$21.89. This amount multiplied by the annual wage index for this facility of 0.9442 yields an adjusted labor-related amount of \$20.67. The non-labor related portion is 40% of the APC rate or \$14.59. The sum of the labor and non-labor related amounts is \$35.26. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.182. This ratio multiplied by the billed charge of \$115.25 yields a cost of \$20.98. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of \$35.26 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is \$3,420.93. The allocated portion of packaged costs is \$3,420.93. This amount added to the service cost yields a total cost of \$3,441.91. The cost of this service exceeds the annual fixed-dollar threshold of \$2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is \$3,380.20. 50% of this amount is \$1,690.10. The total APC payment for this service, including outlier payment, is \$1,725.36. This amount multiplied by 200% yields a MAR of \$3,450.72.
- Procedure code 11008 has a status indicator of C, which denotes inpatient procedures not paid under OPPS. The requestor did not meet the requirements as set forth in 28 Texas Administrative Code §§ 134.403(i) and (j) for performing this procedure in an alternative facility setting. Reimbursement is not recommended.

- Procedure code J1885 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J2001 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J2175 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J2710 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
4. The total allowable reimbursement for the services in dispute is \$3,527.24. This amount less the amount previously paid by the insurance carrier of \$182.20 leaves an amount due to the requestor of \$3,345.04. This amount is recommended..

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$3,345.04.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$3,345.04, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a *certificate of service demonstrating that the request has been sent to the other party.***

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.